Together for Quality Stakeholder Council
Alabama Medicaid Agency
Tuesday, June 12, 2007

I. **Attendees**: See sign-in sheet.

II. **Welcome and Introductions:** Kathy Hall welcomed the attendees and asked that everyone introduce themselves. Mary Finch joined the meeting via conference call as she was attending the State Medicaid Director's Meeting in Vermont. Mary expressed her appreciation for everyone's dedication and hardwork and stated that she had many colleagues asked about the Alabama project. Mary reported that many states were interested in the Alabama project and were looking for us to succeed. She stated that Alabama was ahead of many states and that she personally was proud to be part of the project.
Mary introduced Kim Davis-Allen as the new Project Director. Kim currently serves as the Director of Medical Services and will assume this role along with her current duties. The fit is logical in that the Patient 1st Program is the cornerstone for TFQ and this program is under Kim's direction. In addition to Kim, the Agency has formed a grant unit to support grant activities. Tina Ledbetter, RN and Rita Bell have been named to the unit. At this time, Mary turned to meeting back to Kathy Hall and Kim Davis-Allen.

Kathy reminded the group that the Steering Committee would meet immediately following the Council meeting.

III. **RFP Process:** Kathy Hall reported that the Agency is preparing an RFP to secure vendor services under the grant. After meeting with the Dept. of Purchasing, it was felt that the Agency was securing professional services which can best de defined and evaluated through the RFP vs ITB process. The RFP process allows the Agency to consider a variety of solutions and can evaluate bids on other factors than price alone. She pointed out that any equipment needed to support TFQ would have to be purchased outside the RFP process and through existing State contracts. The Agency has researched other state RFPs for information as well reviewed the proposals submitted in response to the RFI request. The target date for RFP Release is June 29, 2007. The due date for the bids is scheduled for August 20th with a anticipated award of October 1, 2007. Complete information will be contained in the RFP regarding pre-bid questions and deadline dates.

It has been decided that once complete, the RFP will be posted on the Agency website and all vendors on the State Purchasing list will receive a letter indicating that it is available. It was requested that an email be sent via listserv that the RFP has been posted.

IV. **Policy Workgroup:**

The Policy Workgroup held its meetings on May 9 and May 23, 2007. The primary focus of the workgroup this month has been the review of the State agency survey results and the development of criteria for the selection of a partner HHS agency for interoperability. Survey results revealed that all agencies have similar data exchanges and resources concerns. Members of the workgroup discussed three concepts which were: eligibility intake and determination, care management and client database/program referral. These concepts are being further developed and will be finalized at the first June meeting.

The workgroup also finalized policies for the Steering Committee Operating Procedures, contact with vendors and data requests which will be presented to the Steering Committee for approval.

V. **Finance Workgroup:**

Several members of the Finance Workgroup participated in the review of the RFI responses and are assisting in preparation of the RFP/ITB. The Medicaid Agency co-chairs of this workgroup continue to meet bi-weekly with the Medicaid Agency co-chairs of the other workgroups in order to coordinate our activities and to be aware of any issues raised by the other workgroups that might impact our function. The next steps of the workgroup are:

- To prepare a list of functionalities/H.I.E. features that can be used in the Alabama cost model for Phase 2 of the projects. The Florida model as well as other states' models will be used to develop this cost model/business plan.

- Will determine the need for a health care market assessment in Alabama by reviewing a toolkit provided by EHI and consider outside resources to assist with its development.

One of the milestones of the grant that affects both the policy and finance group is the development of sustainability models. Both of these workgroups will be working in this area. The Council is welcomed and encouraged to submit ideas and recommendations in this area.

VI. **Privacy Workgroup:**

The Privacy Workgroup held its monthly meeting by Teleconference on 5/17/07. Further discussion was held on the issue of recipient consent and whether the project should be based on mandatory participation, allowing opt-out, or requiring express opt-in before using a recipient's data. Leigh Mattox will look at some of Blue Cross/Blue Shield's policies and report back to the group.

The Workgroup Milestone regarding review of state and national legislation regarding data sharing and confidentiality was also discussed. Kathy Sauer mentioned she had some

resources available through the Governor's Office on this subject and would look into what might be helpful for the Workgroup.

The next Privacy Workgroup meeting is scheduled for 06/21/07.

VII. **Technical Workgroup:**

The Technical workgroup continues to meet all required objectives and goals. Members of the technical team are heavily involved in the development of the RFP. Dr. Jerry Harrison has compiled a list of required fields for the EHR which is Attachment A. This list will be incorporated by the Clinical Workgroup as they move forward in finalizing requisite data fields. As of today, the Technical Workgroup has met all required objectives in accordance with our assigned list of tasks. The Technical Workgroup has held weekly conference calls to discuss and resolve issues. The following is the status of several items being considered by the workgroup:

- A proposal is being submitted to the Steering Committee regarding the purchase of Citrix® Presentation Server™. This is an end-to-end application and data delivery system. Presentation Server™ will be used to support the TFQ initiative by enabling HIPAA Security Rule (45 C.F.R. Part 164) compliant remote access for any stakeholder, with any device, working over any network. With Presentation Server™ secure architecture, remote access to HIPAA protected health information, IRS protected tax information and other Medicaid confidential information can be controlled, audited, and encrypted. (Attachment B is the complete proposal). During the meeting, it was asked about having to go our for bid for this equipment. Would the Agency and/or should the Agency. It was explained that this service was available through the State contract for equipment; therefore essentially it has been bid.

- The Technical Workgroup submitted a middleware Enterprise Service Bus (EBS) on how the Alabama Department of Finance Information Services Division (ISD) Chief Information Officer (CIO) of Alabama sees its role in this project. In our internal TFQ discussion on June 7, Agency TFQ participants voiced concerns about the TFQ grant funds being expended for the sole outright purchase of BizTalk as recommended in writing by Microsoft when other vendors in their RFI responses cited other products that would produce the same results. TFQ participants felt that nothing would exclude ISD from purchasing this BizTalk product with non-grant funds. Also, there was concern of the participants that the outright purchase of this product from the TFQ grant funds could allow Microsoft to have an unfair advantage over other vendors' products due to their current level of effort in Alabama.

  Agency staff met with ISD staff to further discuss the pros and cons of the outright purchase of BizTalk. A complete proposal, including the justification of why this is in the best interest of the project, will be provided to the Steering Committee.

- According to our group, at this time, we do not see a need to refocus or re-prioritize any task. As a Technical Workgroup, our tasks mainly revolve around what the other workgroups dictates in implementing the technical tasks. The Technical Workgroup did submit a list or issues that need to be resolved early in this project. It is vital that the operating business rules for this project be defined and developed by the Clinical Workgroup. The Technical Workgroup mission is to ensure that what ever the other workgroups business rules requires can be implemented from a sound technical standpoint. Technical Workgroup think that the Clinical Workgroup need to get with or survey the providers, based on comments of providers, in developing the screen layout for this project. Many of the concerns that have been expressed are being addressed in the RFP development process.

VII. **Clinical Workgroup**

The Clinical Workgroup held conference calls on May 9, May 16 and May 30. The group convened after the Stakeholder Council meeting on May 9th initially discussing the data elements and the table submitted by Anita Cowden with ADPH. The group was asked if there were any additional data elements or if there were elements noted which needed to be removed. The group had no additions or subtractions to the data elements and the table submitted was accepted as complete for submission to the Technical Workgroup.

The diabetes domain experts were asked to review the measures chosen by the group and to comment as to whether these measures were sufficient or whether additional ones were needed. Both Drs. Ambika Ashraf and Fernando Ovalle indicated that the group had chosen some good measures. They were then asked to rank the measures. The measures were ranked as follows:

1. HbA1C – percentage of patients who have had at least one HbA1C during 12 month review period and percentage of patients who have had two or more HbA1Cs during the 12 month review period
2. Lipid Management – percentage of patients who received at least one lipid profiles (or ALL component tests) during the 12 month review period
3. Annual Urine Protein Screening (or microalbumin) during the 12 month review period
4. Annual Eye Exam – percentage of patients who received a dilated eye exam by an ophthalmologist or optometrist during the 12 month review period
5. Annual Influenza Immunization – percentage of patients who received an influenza vaccination during the recommended calendar period.

Discussion continued on the QI measures above with Dr. Ashraf indicating that there were differences for children with the recommended frequency in testing for type 1 versus type 2 diabetes. The frequency for children with type 2 diabetes

is the same as for adults while the frequency for children with type 1 depends on age or time since first diagnosis. Dr. Ashraf was to provide clarification as to the recommended frequency for the lipid profile and eye exams for children and Dr. McIntyre indicated that she would get this information back out to the group. The measures would then be discussed with the Statistical Support Unit to verify that this data could be pulled. Following the May 9th meeting several emails were sent concerning the diabetes measures and changes needed for children. Concurrence was obtained from three diabetes experts; Dr. Elaine Moreland, Dr. Ambika Ashraf and Dr. Fernando Ovalle and the final diabetes QI measures follow:

6. HbA1C – percentage of patients who have had at least one HbA1C during 12 month review period and percentage of patients who have had two or more HbA1Cs during the 12 month review period **(Children and Adults)**
7. Lipid Management – percentage of patients who received at least one lipid profile (or ALL component tests) during the 12 month review period **(Adults and Chidren≥16 years old)**
8. Annual Urine Protein Screening (or microalbumin) during the 12 month review period **(Adults and Chidren≥16 years old)**
9. Annual Eye Exam – percentage of patients who received a dilated eye exam by an ophthalmologist or optometrist during the 12 month review period **(Adults and Chidren≥16 years old)**
10. Annual Influenza Vaccination – percentage of patients who received an influenza vaccination during 12 month review period **(Children and Adults)**

The group met on May 16th. The pediatric clarification for the diabetes QI measures was discussed and members agreed with the changes made and the diabetes measures were considered final. Discussion then moved to the Asthma QI measures. Some members had submitted comments and concerns for discussion by the group. The differentiation of asthma controller versus relief medications was discussed. The group determined the following measures for presentation to the asthma domain/content experts at the next call:

1. Asthma Controller Use/Use of Appropriate Medications
2. Annual Influenza Immunization
3. Emergency Department Use (Asthma Related)
4. Hospital Admissions (Asthma Related)
5. Pulmonary Function Testing (PFTs) at least once a year for anyone ≥ 6 years old

On May 30th the Clinical group met with the asthma domain experts to discuss the asthma measures. There was a lot of discussion on the measures and concerns were voiced that we would be leaving out "high risk" patients with where some of the levels were currently set. While it appeared that the group had come to some agreement at the end of the call concerns were voiced and additional comments were received and circulated. Dr. Meadows' recommendations were submitted to the group and will be discussed again on June 13th for finalization.

The meeting dates for the month of June for Clinical are **June 13, June 20** and **June 27.** All meetings are 4:00pm Conference Calls.

Next Steps

- Finalize Asthma QI Measures
- Establish baselines for QI indicators with clarification of numerators and denominators including age, timeframes, etc.
- Establish criteria for inclusion/exclusion for the provider pilot group

VIII. **Second Solicitation**

CMS has released additional funding through a 2nd grant solicitation. A call was held with Stakeholders to solicit ideas. Below is the concept that will be the basis of the 2nd solicitation for grant funds. The deadline for submission is June 15th.

Develop a new infant tracking database that contains electronic health records based on clinical and social notes from service providers. The focus will be the collection of data pertaining to the mother's ob history, present ob situation, baby's birth and 1st year of life.

Data will be fed into the electronic health record at the time of mother's entry into the Maternity Care Program and will be primarily data pertaining to ob history indicators, antenatal course, risk factors – both social and medical, delivery outcome including birthweight and baby conditions (e.g. spina bifida). At the time the baby is born, the dataset will be expanded to collect information about the baby specifically related to clinical notes about development that may not be captured through claims history.

The clinical notes will be augmented with claims information as well as a clinical decision support system identifying risks and appropriate interventions. The system will also have built in "flags" for social needs such as redetermination date.

The purpose is to have a more "robust" set of data that will collect information above the typical claims based information.

IX. **Meeting Schedules/Venues**

Kim Davis-Allen again expressed the Agency's appreciation for the level of dedication and involvement shown by the stakeholders. The meeting today lasted approximately one hour.

In trying to appreciate everyone's time, the possibility of changing the meeting venue was discussed.

- Robin Rawls reported on her research regarding web-cast. In order to be able to participate in a web-cast, there has to be the capability on both the sending and receiving end. Many of the public health departments; larger hospitals and academic centers have this ability For the most part, stakeholders would not have the ability to participate from their offices.
- The possibility of posting all the reports on the WEB and then having only a conference call was discussed. There are the issues with people being able to clearly hear all the presenters via conference call.
- The possibility of having meetings only bi-monthly or quarterly was discussed. Now that the workgroups are firmly established and the milestones decided and are being met, perhaps the there is not a need to meet monthly. The status reports could still be posted to the WEB on a monthly basis. Most of the work is being accomplished via the workgroups and just being reported to the Stakeholders.
- The possibility of scheduling a series of meetings for the same day was also presented. For example, for those stakeholders that participate in various workgroups, have those meetings on the same day as the Stakeholders Council.

The group did not express any strong opinions. Dr. Harrison did point out that the meetings, both the workgroups and the stakeholder meetings, did require him to be away from his practice and that was an issue for providers. In light of the July holiday and everyone's schedule, the face-to-face meeting for July is cancelled. The status report will still be posted to the WEB by the July 11th date.

In addition, the group was reminded that there is a meeting calendar for all meetings regarding TFQ on the Agency's website. Workgroup co-chairs are encouraged to put pertinent information about their individual meetings on the website so that participants can make decisions about whether to participate. The Agency does recognize the frequency of the meetings and is open to ways to make it easier for stakeholders to participate.

X. **In Closing**

- The development of the RFP is the main focus of TFQ activities at this time.
- Agency co-chairs and other staff meet on a weekly basis to discuss issues and to ensure that everyone is fully engage in this project. The Agency realizes that there are critical decisions that must be made timely in order to meet deadlines. Stakeholders were encouraged to submit to their workgroup or to Kim Davis-Allen what they thought were critical decisions that needed to be made.

THE NEXT FACE-TO-FACE STAKEHOLDERS MEETING WILL BE HELD AUGUST 8, 2007. THE JULY STATUS REPORT WILL BE SUBMIITED BY JULY 11, 2007.

Requirements for the TFQ Product

1. "Demographics
    a. Name, nickname, maiden name, other search name or alternate spellings
    b. Sex, dob, ssn, cell phone, home phone, work phone, emergency contact phone and name, email address,
    c. Insurance numbers including Medicare part d if applicable
    d. Scanned image of drivers license, insurance & pharmacy cards
    e. Photograph of patient
2. Allergies & Intolerances
    a. Drugs
    b. Foods and other important elements
3. Alerts these are notifications set to: Provider, Medical Group, or System wide alerts. Examples include.
    a. Inform patient to bring Blood sugar & Weight to all Appts (Group Specific)
    b. Frequent Loss of narcotic Rx's (System Wide)
    c. Dr Smith will exclusively provide all pain medicines (System Wide)
    d. Only morning appt for this patient. (Talks a lot) Provider Specific)
    e. Collect Serum ammonia Level on every visit. (Group Specific)
4. Health suggestion
    a. Immunizations
    b. Recurring health maintenance time sensitive i.e., pap smear, mammogram, prostate exam, colon screening
    c. Disease triggered suggestions, i.e. for diabetics need Hgb A1c quarterly, eye exam yearly, foot exam, micro albumin, etc. For heart failure left ventricular function assessment, inhaled steroids for asthma etc.
5. Vital signs, to include bp / pulse / respiration / weight and through local configuration height, smoking, pain, oxymetery
6. chief complaints this should be entered from search list for template setup with optional text entry if prefers.
7. Social history
    a. Smoker, etoh, (and years of risk)
    b. drugs of abuse
    c. Occupation
    d. Children
    e. Education
    f. Marital number and current status, lifestyle
    g. Housing Status
8. Medication
    a. Medications from other providers accessed through the prescription database for controlled substances should be seen by the PHYSICIAN
    b. Sorted by system, active medications at top

    c. Inactive medication only if requested
    d. Ultimately prescriptions written and not filled should show up as this is just as important as what the patient is taking
9. Diagnoses
    a. Active (Sorted by system)
    b. Inactive only if requested
10. Procedures and results should indicate date, where performed and by whom (Conclusions should be available in text format so as to be succinct) but original images should also be viewable ie Faxes, Xrays, PDFs etc.
    a. Imaging studies
    b. GI, Cardiology, Neurology, Radiology Studies
    c. Surgical procedures & Discharge Summaries should also be listed
    d. Interventions such as chemotherapy
    e. Consultation Reports by Specialists
11. Lab
    a. System should be Group & Provider Configurable to display certain LAB results on the main screens, e.g HgbA1c for diabetics
    b. Trending of lab values in a different screen (tab) and ultimately source of lab values when integration of lab from diverse sources (hospital, reference lab, office lab, other physicians, emergency rooms)
    c. Easy insertion of lab value at the point of service
12. Functional elements
    a. Ability to electronically transmit prescriptions preferably via fax
    b. Pharmacy telephone numbers & Addresses, fax numbers, Medicaid Numbers, email, escribe identifiers should be integrated into the program to facilitate prescription transmission
    c. Ability to print all prescriptions including the controlled substance
    d. Internet verification of prescriptions for pharmacies
    e. Unique Prescription numbers (for use by pharmacy systems) should be initiated by the physician. This is a significant deviation from current activity but is much more advantageous to the patient and physician and does not impact the pharmacy adversely. This allows patients to pick a pharmacy after they leave the physician's office and to change their mind or fill different prescriptions at different pharmacies without confusion or the need for transfer. Pharmacies would pull the information into their pharmacy systems once a unique prescription number was presented to them either by paper RX PAD or emailed or transmitted.
    f. Healthcare recommendation/suggestions based on diagnosis, medicines, Habits. family history, age, race, sex, starting with the diseases/conditions outlined in the grant
    g. Incremental participation with full internet functionality. All ER's could access the internet to check on patients immediately without purchase of additional equipment. This could give valuable information about patients to the ER and to the patient's first physician.

h. Referrals. This would integrate with patient first and the referral could be integrated with the product
i. Participating physicians would have the advantage of having their identification immediately available to geographically acceptable referral doctors. Also, this would verify the referral.
j. With the referral then report could be made back to the same repository for synchronization. Each physician would have the possibility of participating at several levels including the initial 500 in the grant as fully participating with EMR or health record.
k. There would be local data for an individual provider but this would be background synchronized
l. Real-time evaluation of physician compliance with recommendations could be viewed although this should NOT be part of the medical record but used instead for CQI.
m. Likewise, at the beginning of the initiation the entire claims made database should be mined to arrive at a beginning 'grade' for Medicaid. This could be given to Medicaid as a whole and to individual practitioners who could then at their desire compare themselves to other practitioners or critique themselves for compliance. This would be much more practical than looking at the multiple pages sent about compliance.
n. Integration of clinical aspects of the diverse multiple databases including BCBS infosolution database, immunization, reportable disease, Medicaid claims, ADPH, should be the first priority of the clinical portion of the grant implementation. "

Proposal Regarding Citrix Presentation Server

Citrix® Presentation Server™ is an end-to-end application and data delivery system. Presentation Server™ will be used to support the TFQ initiative by enabling HIPAA Security Rule (45 C.F.R. Part 164) compliant remote access for any stakeholder, with any device, working over any network. With Presentation Server™ secure architecture, remote access to HIPAA protected health information, IRS protected tax information and other Medicaid confidential information can be controlled, audited, and encrypted.

The following represent the cost estimate to implement the proposed Citrix® Presentation Server™ solution:

Hardware and OS Licensing:	$12,500 per server for 2 servers	$25,000
Citrix Licensing:	$360 per user for 50 concurrent users	$18,000
Terminal Server CALs:	$90 per user for 200 total users	$18,000
Training:	1 Architect and 2 Administrators	$17,000

3 staff members will be trained to the levels of:

- Citrix Certified Integration Architect
- Citrix Certified Enterprise Engineer
- Citrix Certified Administrator

TOTAL: $78,000

It is recommended that Citrix® Presentation Server™ be bought outright and owned by Medicaid.